Photo

U. S. Department of State

MEDICAL EXAMINATION FOR IMMIGRANT OR REFUGEE APPLICANT

For use with TB Technical Instructions 2007 and the DS-3030

OMB No. 1405-0113
EXPIRATION DATE: 07/31/2013
ESTIMATED BURDEN: 10 minutes
(See Page 2 - Back of Form)

Name *(Last, First, MI.)* _____, _____, _____

Birth Date *(mm-dd-yyyy)* _____ **Sex:** ☐ **M** ☐ **F**

Birthplace *(City/Country)* _____ / _____

Present Country of Residence _____ **Prior Country** _____

U.S. Consul *(City/Country)* _____ / _____

Passport Number _____ **Alien** *(Case)* **Number** _____

Date of Medical Exam *(Date of TB physical exam or date of lab report of final TB culture results, if cultures performed) (mm-dd-yyyy)* _____

Date Exam Expires *(3 months if Class A TB, or Class B1 TB, otherwise 6 months) (mm-dd-yyyy)* _____

Date *(mm-dd-yyyy)* **of Prior Exam, if any** _____ **Exam Place** *(City/Country)* _____ / _____

Panel Physician _____ **Radiology Services** _____

Screening Site _____ **Lab** *(Name for syphilis/TB)* _____ / _____ / _____

(1) Classification *(Check all boxes that apply):*

☐ **No apparent defect, disease, or disability** *(See Worksheets DS-3025, DS-3026, and DS-3030)*

☐ Class A Conditions *(From Past Medical History and Physical Examination Worksheets)*

- ☐ TB, active, infectious *(Class A, from Chest X-Ray Worksheet)*
- ☐ Syphilis, untreated
- ☐ Chancroid, untreated
- ☐ Gonorrhea, untreated
- ☐ Granuloma inguinale, untreated
- ☐ Lymphogranuloma venereum, untreated
- ☐ Hansen's disease, untreated multibacillary
- ☐ Addiction or abuse of specific* substance without harmful behavior
- ☐ Any physical or mental disorder *(including other substance-related disorder)* with harmful behavior or history of such behavior likely to recur

*amphetamines, cannabis, cocaine, hallucinogens, inhalants, opioids, phencyclidines, sedative-hypnotics, and anxiolytics

☐ Class B Conditions *(From Past Medical History and Physical Examination Worksheets)*

- ☐ Syphilis *(with residual defect)*, treated within the last year
- ☐ Other sexually transmitted infections, treated within last year
- ☐ Current pregnancy, number of weeks pregnant _____
- ☐ Any physical or mental disorder *(excluding addiction or abuse of specific* substance but including other substance-related disorder)* without harmful behavior or history of such behavior unlikely to recur
- ☐ Hansen's disease, treated multibacillary
  Treatment: ☐ Partial ☐ Completed
- ☐ Hansen's disease, paucibacillary
  Treatment: ☐ None ☐ Partial ☐ Completed
- ☐ Sustained, full remission of addiction or abuse of specific* substances

*amphetamines, cannabis, cocaine, hallucinogens, inhalants, opioids, phencyclidines, sedative-hypnotics, and anxiolytics

☐ Class B1 TB, Pulmonary

- ☐ No treatment
- ☐ Completed treatment *(Check all that apply and attach all laboratory and DOT documents)*
  - ☐ By panel physician
  - ☐ Initial smear positive
  - ☐ Pre-treatment culture and DST results performed/available
  - ☐ By non-panel physician
  - ☐ Initial culture positive
  - ☐ Pre-treatment culture and/or DST results not performed/available

☐ Class B1 TB, Extrapulmonary

Anatomic Site of Disease _____

- ☐ No treatment
- ☐ Current treatment
- ☐ Completed treatment

☐ Class B2 TB, LTBI Evaluation

- ☐ Test for TB infection positive: ☐ TST _____ mm; ☐ IGRA positive Result _____ ☐ TST or IGRA Conversion
  - ☐ No LTBI treatment
  - ☐ Current LTBI treatment *(Indicate medications in Part 4 of DS-2054 form)*
  - ☐ Completed LTBI treatment *(Indicate medications in Part 4 of DS-2054 form)*

Class B Tuberculosis - Continued

☐ **Class B3 TB, Contact Evaluation**

☐ TST ____ mm ☐ IGRA negative ☐ IGRA positive IGRA Result _____

☐ No preventive treatment

☐ Current preventive treatment *(Indicate medications in Part 4 of DS-2054 form)*

☐ Completed preventive treatment *(Indicate medications in Part 4 of DS-2054 form)*

Source Case: Name _____

Alien Number _____

Relationship to Contact _____

Date Contact Ended *(mm-dd-yyyy)* _____

Type of Source Case TB *(Mark only one and **ATTACH DST RESULTS**)*

☐ Pansusceptible TB

☐ MDR TB (resistant to at least INH and rifampin)

☐ Drug-resistant TB other than MDR TB

☐ Culture negative

☐ Culture results not available

☐ **Class B Other** *(specify or give details on checked conditions from worksheets)* _____

_____

_____

_____

(2) Laboratory Findings *(check all boxes that apply):*

Syphilis: ☐ **Not done**

	Test Name	Date(s) Run *(mm-dd-yyyy)*	Negative	Positive	Titer 1	Notes
Screening						
Confirmatory						

Treated	If treated, therapy:	Date(s) treatment given *(mm-dd-yyyy) (3 doses for penicillin)*
☐ Yes	☐ Benzathine penicillin, 2.4 MU IM	
☐ No	☐ Other *(therapy, dose)*: _____	

(3) Immunizations *(See Vaccination Form, check all boxes that apply)* **Not required for refugee applicants.**

☐ Vaccine history complete

☐ Vaccine history incomplete, requesting waiver *(indicate type below)*

☐ Incomplete vaccine history, no waiver requested

☐ Blanket waiver ☐ Individual waiver

I certify that I understand the purpose of the medical examination and I authorize the required tests to be completed.

Applicant Signature	Panel Physician Signature	Date *(mm-dd-yyyy)*

(4) Tuberculosis Treatment Regimen

(Fill out if applicant has taken in the past, or is now taking TB medication. If drug doses or dates not known or not available, mark "unknown".)

☐ Check if therapy currently prescribed *(if current, don't mark "End Date")*

Medication	Dose/Interval *(i.e., mg/day)*	Start Date *(mm-dd-yyyy)*	End Date *(mm-dd-yyyy)*
☐ Isonaizid (INH)			
☐ Rifampin			
☐ Pyrazinamide			
☐ Ethambutol			
☐ Streptomycin			
☐ Other, specify			

Applicant's pre-treatment weight (kg) _____ Date *(mm-dd-yyyy)* _____

Remarks _____

PAPERWORK REDUCTION ACT AND PRIVACY ACT NOTICES

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CONFIDENTIALITY STATEMENT

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PURPOSE The U.S. Department of State uses the facts you provide on this form primarily to determine your classification and eligibility for a U.S. immigrant visa. Individuals who fail to submit this form or who do not provide all the requested information may be denied a U.S. immigrant visa. Although furnishing this information is voluntary, failure to provide this information may delay or prevent the processing of your case.

ROUTINE USES If you are issued an immigrant visa and are subsequently admitted to the United States as an immigrant, the Department of Homeland Security will use the information on this form to issue you a Permanent Resident Card, and, if you so indicate, the Social Security Administration will use the information to issue a social security number. The information provided may also be released to federal agencies for law enforcement, counterterrorism and homeland security purposes; to Congress and courts within their sphere of jurisdiction; and to other federal agencies who may need the information to administer or enforce U.S. laws.

U.S. Department of State

CHEST X-RAY AND CLASSIFICATION WORKSHEET

For use with TB TI 2007 and the DS-2054

Complete Sections 1 through 5, As Applicable

OMB No. 1405-0113
EXPIRATION DATE: 07/31/2013
ESTIMATED BURDEN: 10 MINUTES
(See Page 2 - Back of Form)

Name *(Last, First, MI.)*	Age

Birth Date *(mm-dd-yyyy)*	Passport Number	Alien (Case) Number

1. Chest X-Ray Indication *(Mark all that apply)*

- ☐ Age ≥ 15 years
- ☐ Signs or symptoms of tuberculosis
- ☐ HIV infection

Test for TB infection:

- ☐ TST≥10 mm; Result_____ mm; Date *(mm-dd-yyyy)*_____
- ☐ IGRA Positive; Result _____ Date *(mm-dd-yyyy)* _____

(If child does not have any of the above, stop here.)

2. Chest X-Ray Findings **Date Chest X-Ray Taken** *(mm-dd-yyyy)* _____

- ☐ Normal Findings
- ☐ Abnormal Findings *(Indicate category and finding, checking all that apply in the table below.)*

☐ **Can Suggest Tuberculosis** ***(Need Smears and Cultures)***		☐ **Other X-Ray Findings**
☐ Infiltrate or consolidation	☐ Discrete linear opacity (fibrotic scar)	☐ Follow-up needed (Mark as Class B Other)
☐ Any cavitary lesion	☐ Discrete nodule*(s)* without calcification	☐ Musculoskeletal
☐ Nodule or mass with poorly defined margins *(such as tuberculoma)*	☐ Discrete linear opacity (fibrotic scar) with volume loss or retraction	☐ Cardiac
☐ Pleural effusion*****	☐ Other (such as bronchiectasis)	☐ Pulmonary, non-TB (e.g., emphysema)
☐ Hilar/mediastinal adenopathy with or without atelectasis		☐ Other
☐ Other *(such as miliary findings)*		☐ No follow-up needed for pleural thickening, diaphragmatic tenting, calcified pulmonary nodule(s), calcified lymph node(s), calcified lymph node(s) with calcified pulmonary nodule(s), or minor musculoskeletal findings.
* If unclear whether pleural fluid or thickening, perform lateral or decubitus chest radiograph, or targeted ultrasound.		

Remarks

_____

_____

_____

_____ _____

Radiologist's Signature Date Interpreted *(mm-dd-yyyy)*

3. Sputum Smears and Cultures

- ☐ No, not indicated - Applicant has no signs or symptoms of TB, no HIV infection, and:
  - ☐ X-ray Normal and test for TB infection negative (if performed): this is No Class
  - ☐ X-ray Normal and test for TB infection positive (if performed): this is Class B2 TB, LTBI Evaluation
- ☐ Yes, are indicated - Applicant has (Mark all that apply):
  - ☐ Signs or symptoms of TB
  - ☐ Chest X-ray suggests TB
  - ☐ HIV infection

Sputum Smear Results

Date Obtained *(mm-dd-yyyy)*	Positive	Negative

Sputum Culture Results

Date Obtained *(mm-dd-yyyy)*	Positive	Negative	NTM*	Contaminated

* Nontuberculous Mycobacteria

- ☐ Positive Smear or Culture Result; this is a Class A TB
- ☐ Negative Smear and Culture Results and:
  - ☐ Chest X-Ray suggests TB or signs and symptoms of TB: Class B1 TB, Pulmonary
  - ☐ HIV infection with normal X-ray and no signs and symptoms of TB: No Class for TB

TURN PAGE OVER TO FINISH DS-3030 FORM

4. Classifications *(Mark all that apply and also provide complete information on the DS-2054)*

- ☐ No Class
- ☐ Class A TB
- ☐ Class A TB with waiver
- ☐ Class B1 TB, Pulmonary
- ☐ Class B1, TB, Extrapulmonary
- ☐ Class B2 TB, LTBI Evaluation
- ☐ Class B3 TB, Contact Evaluation
- ☐ Class B Other

5. Remarks

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U.S. Department of State

VACCINATION DOCUMENTATION WORKSHEET

For Use with DS-2053 or DS-2054 — To Be Completed by Panel Physician Only

OMB No. 1405-0113
EXPIRATION DATE: 07/31/2013
ESTIMATED BURDEN: 30 minutes
(See Page 2 of 2)

Name *(Last, First, MI.)*		Exam Date *(mm-dd-yyyy)*
Birth Date *(mm-dd-yyyy)*	Passport Number	Alien (*Case*) Number

REQUIRED FOR U.S. IMMIGRANT VISA APPLICANTS

NOT REQUIRED FOR REFUGEE APPLICANTS

NOTE FOR PANEL PHYSICIANS:
For refugee applicants, please complete only if reliable vaccination documents are available.

1. Immunization Record

Vaccine	Vaccine History Transferred From a Written Record *(List Chronologically from Left to Right)* Date Received *(mm-dd-yyyy)*	Date Received *(mm-dd-yyyy)*	Date Received *(mm-dd-yyyy)*	Date Received *(mm-dd-yyyy)*	Vaccine Given by Panel Physician *(mm-dd-yyyy)*	Completed Series *(✓ if Completed, Write "VH" if Varicella History, or write Date of Lab Test if Immune)*	Blanket Waiver(s) To Be Requested If Vaccination Not Medically Appropriate, Check Suitable Box(es) Below: Not Age Appropriate	Insufficient Time Interval	Contra-indicated	Not Routinely Available	Not Fall *(Flu)* Season
Specify (*check*) vaccine: ☐ DT ☐ DTP ☐ DTaP											
Specify (*check*) vaccine: ☐ Td ☐ Tdap											
Specify (*check*) vaccine: ☐ Polio -OPV ☐ IPV											
Specify (*check*) vaccine: ☐ MMR (Measles-Mumps-Rubella) ☐ Rubella Specify (*check*) vaccine: ☐ Measles ☐ Measles - Rubella Specify (*check*) vaccine: ☐ Mumps ☐ Mumps - Rubella											
Rotavirus											
Hib											
Hepatitis A											
Hepatitis B											
Meningococcal											
Human papillomavirus											
Varicella											
Zoster											
Pneumococcal											
Influenza											

2. Results

☐ Vaccine History Incomplete

☐ Applicant may be eligible for blanket waiver(s) because vaccination(s) not medically appropriate *(as Indicated Above)*.

☐ Applicant will request an individual waiver based on religious or moral convictions.

☐ Vaccine history complete for each vaccine, all requirements met *(Documented Above)*.

☐ Applicant does not meet vaccination requirements for one or more vaccines and no waiver is requested.

3. Panel Physician *(Name)* _____

Panel Physician *(Signature)* _____

Date *(mm-dd-yyyy)* _____

U.S. Department of State

MEDICAL HISTORY AND PHYSICAL EXAMINATION WORKSHEET

For use with DS-2053 or DS-2054

OMB No. 1405-0113
EXPIRATION DATE: 07/31/2013
ESTIMATED BURDEN: 35 minutes
(See Page 2 - Back of Form)

Name *(Last, First, MI)*		Exam Date *(mm-dd-yyyy)*
Birth Date *(mm-dd-yyyy)*	Passport Number	Alien *(Case)* Number

1. Past Medical History *(indicate conditions requiring medication or other treatment after resettlement and give details in Remarks)*

NOTE: The following history has been reported, has not been verified by a physician, and should not be deemed medically definitive.

No	Yes	
		General
☐	☐	Illness or injury requiring hospitalization *(including psychiatric)*
		Cardiology
☐	☐	Angina pectoris
☐	☐	Hypertension *(high blood pressure)*
☐	☐	Cardiac arrhythmia
☐	☐	Congenital heart disease
		Pulmonology
☐	☐	History of tobacco use Current use ☐ Yes ☐ No
☐	☐	Asthma
☐	☐	Chronic obstructive pulmonary disease *(emphysema)*
☐	☐	History of tuberculosis *(TB)* disease Treated ☐ Yes ☐ No Current TB symptoms ☐ Yes ☐ No
		Neurology and Psychiatry
☐	☐	History of stroke, with current impairment
☐	☐	Seizure disorder
☐	☐	Major impairment in learning, intelligence, self care, memory, or communication
☐	☐	Major mental disorder *(including major depression, bipolar disorder, schizophrenia, mental retardation)*
☐	☐	Use of drugs other than those required for medical reasons
☐	☐	Addiction or abuse of specific* substance *(drug)* *amphetamines, cannabis, cocaine, hallucinogens, inhalants, opioids, phencyclidines, sedative-hypnotics, and anxiolytics
☐	☐	Other substance-related disorders *(including alcohol addiction or abuse)*
☐	☐	Ever taken action to end your life

No	Yes	
☐	☐	Ever caused SERIOUS injury to others, caused MAJOR property damage or had trouble with the law because of medical condition, mental disorder, or influence of alcohol or drugs
		Obstetrics and Sexually Transmitted Diseases
☐	☐	Pregnancy Fundal height _____ cm Last menstrual period Date *(mm-dd-yyyy)* _____
☐	☐	Sexually transmitted diseases, specify _____
		Endocrinology and Hematology
☐	☐	Diabetes mellitus
☐	☐	Thyroid disease
☐	☐	History of malaria
		Other
☐	☐	Malignancy, specify _____
☐	☐	Chronic renal disease
☐	☐	Chronic hepatitis or other chronic liver disease
☐	☐	Hansen's Disease ☐ Multibacillary ☐ Paucibacillary Treated ☐ Yes ☐ No
☐	☐	Visible disabilities *(including loss of arms or legs)*, specify
☐	☐	Other requiring treatment, specify

2. Physical Examination *(indicate findings and give details in Remarks)*

☐ No ☐ Yes Applicant appears to be providing unreliable or false information, specify

Height _____ cm Weight _____ kg Visual Acuity at 20 feet: Uncorrected L 20/ _____ R 20/ _____

BP ____ / ____ *(mmHg)* Heart rate _____ /min Respiratory rate ____ /min Corrected L 20/ _____ R 20/ _____

***N, normal; A, abnormal; ND, not done**

N*	A*	ND*	
☐	☐	☐	General appearance and nutritional status
☐	☐	☐	Hearing and ears
☐	☐	☐	Eyes
☐	☐	☐	Nose, mouth, and throat *(include dental)*
☐	☐	☐	Heart *(S1, S2, murmur, rub)*
☐	☐	☐	Breast
☐	☐	☐	Lungs
☐	☐	☐	Abdomen *(including liver, spleen)*
☐	☐	☐	Genitalia *(including circumcision, infection(s))*

N*	A*	ND*	
☐	☐	☐	Inguinal region *(including adenopathy)*
☐	☐	☐	Extremities *(including pulses, edema)*
☐	☐	☐	Musculoskeletal system *(including gait)*
☐	☐	☐	Skin *(including hypopigmentation, anesthesia, findings consistent with self-inflicted injury or injections)*
☐	☐	☐	Lymph nodes
☐	☐	☐	Nervous system *(including nerve enlargement)*
☐	☐	☐	Mental status *(including mood, intelligence, perception, thought processes, and behavior during examination)*

3. Additional Testing Needed Prior to Approving Medical Clearance

No Yes

☐ ☐ Physical examination or laboratory results contradict medical history

☐ ☐ Referral prior to departure If yes, provide results _____

_____

_____

☐ ☐ Referral prior to departure If yes, provide results _____

_____

_____

4. Follow-up Needed After Arrival

☐ No ☐ Yes, within 1 week ☐ Yes, within 1 month ☐ Yes, within 6 months

☐ For continuing medication, list type, dose, and frequency *(Exception: For TB medications, use Part 4 of DS-2053 or DS-2054 form)* _____

_____

☐ For continuing other treatment, specify _____

_____

5. Remarks *(Describe any abnormal history, abnormal findings, and resulting interventions)*

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